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(Information regarding contributions and advertising will be found on the second page following the reading material.)

Editorials

REHABILITATION IN CANADA

A stimulating and informative meeting took place in Toronto on February 18 and 19 last.* This meeting of the Committee on Rehabilitation of the Canadian Medical Association with other interested parties explored before its termination almost every aspect of rehabilitation work in Canada.

This was no routine session but a free and frank exchange of opinion, a heartening display of enthusiasm, and a helpful account of achievement. We hope to publish in this Journal some of the papers given. In the meanwhile, we believe that some reference to the material brought out at this unique conference will interest many of the physicians of Canada.

There seemed to be general agreement that rehabilitation must be sold to the public in general on its economic merits, and not on its sentimental appeal. The community at large must be made to realize that it is sound business to rehabilitate the disabled, and employers must be made to see advantages in hiring disabled persons. This long-term educational approach to employers must eventually replace the front-page story approach.

In discussion of the content of rehabilitation, emphasis was laid on the need for real occupational therapy as opposed to diversional therapy, and on the need for a realistic approach to vocational training. Dr. Steele put the matter succinctly when he said that the average injured Canadian workman only wants a job, and is not interested in going back to school. Careful selection is needed in placement, to avoid antagonizing employers by giving them persons who will break down under the strain of their new job.

Various types of disabled person were discussed. The injured workman naturally attracted much attention, but Dr. Jousse made a plea for the person injured out of working hours, and Dr. Campbell expressed the belief that all in the community should share in the benefits of rehabilitation. Dr. Crawford described rehabilitation in a general hospital, pointing out that with this approach to the acute case the patient's hospital stay might be prolonged but he would be less disabled on discharge. In rehabilitating psychiatric patients (work discussed by Dr. Boothroyd), the first difficulty was the setting of a target. A large proportion of the public still entertained the erroneous view that psychiatric patients could not be cured, while the definition of cure was vague and too much might be expected of psychiatry. The tuberculous represented an increasingly worth-while group of candidates for rehabilitation. Dr. Wherrett explained the factors making this work easier, and made the important point that the mere presence of a rehabilitation team in a hospital is a morale-booster.

Responsibility for rehabilitation was placed squarely on the community. The place to rehabilitate about 90% of the disabled is in their own community, with the general practitioner sitting as judge and jury in assessing the success of the effort. For the problem case, and for the case needing special diagnostic aid or other guidance, there must be a special centre for reference, maybe at the provincial level.

Participants in the conference were well aware of the difficulties involved in providing trained personnel and facilities for rehabilitation. Dr. MacFarlane was pessimistic about the outlook for graduate training of physicians in rehabilitation. At present training was too long and opportunities at the end of it were too limited. There was urgent need for a University-centred training programme. As regards undergraduates, he felt that if medical students could only see good rehabilitation departments at work there would be no need to make special efforts to secure their interest.

Dr. Campbell in his summary of the conference referred to the four tasks of the doctor

*A fuller report appears in this issue on page 543.

in rehabilitation: (1) to prevent or minimize disability in the general hospital; (2) to manage and guide re-training of the long-term patient; (3) to ward off disability in patients under domiciliary medical care or sufferers from chronic disease; (4) to give technical advice to government bodies.

HOME TREATMENT OF TUBERCULOSIS?

With the discovery of various antibiotic and chemotherapeutic agents in the past few years, many changes have taken place in the treatment of tuberculosis. One of the most important changes is the early ambulation of patients and, in some instances, their early discharge.

Recently many articles have appeared in the press concerning the closing of sanatoria due to lack of patients. This has given rise to some false impressions, the main one being that tuberculosis is on the decline and is a disease that can easily be treated at home. While the mortality rate has been reduced markedly, the morbidity rate has not declined correspondingly; over the past few years the decline has been relatively small. Indeed, some authorities question whether there has been any decline in the morbidity rate, although the consensus seems to be that it has been slow but steady. One of the main reasons for a change in management of tuberculosis was the lack of sanatorium beds. With the advent of newer methods of treatment some centres started using drugs on their patients while the latter were awaiting admission. However, it was soon found that this was not a sound method of approach and the policy was then adopted of getting the patient into sanatorium as soon as possible, indoctrinating him on how to "live with his tuberculosis," getting him established on a satisfactory course of drug therapy and discharging him to his home to carry on this treatment. This meant a drastic reduction in the number of months spent in sanatorium, with the result that the waiting lists soon disappeared and all patients could be admitted to sanatorium shortly after the diagnosis had been made.

There have been many criticisms of this form of treatment and many authorities question the long-term result. It is recognized that it is much better to treat a patient at home after a relatively short period in sanatorium than not to treat him at all, and thus the treatment is justified. The long-term effect has not been evaluated and it will take some years before a firm decision can be reached. On the whole, Canadians have been fairly conservative, although in some centres home treatment after a relatively short period of sanatorium stay is being carried out. It is quite possible that eventually we will follow an intermediate course, that is, a reasonably long period of treatment in sanatorium followed by a period of drug therapy at home or at work.

Treatment carried on at home involves extremely careful and regular reassessment of the patient which is made more difficult by the false sense of security engendered in the patient by his accelerated sanatorium treatment.

No one questions the value of sanatorium treatment, and it is safe to say that no one would recommend full treatment on drug therapy at home. It is accepted everywhere that the acute case of pulmonary tuberculosis should be treated in bed in a sanatorium, on adequate drug therapy; when the acute phase passes the treatment should be kept up in a protected environment, preferably in a sanatorium with the patient allowed out of bed a good deal of the time.

Editorial Comments

INFANTILE STRIDOR

Stridor in the infant must be regarded as a symptom and not as a disease *sui generis*. A recent publication[1] lists the possible etiology from lesions such as systemic disease, birth trauma, cortical damage and a wide variety of local abnormalities of the mouth, throat, larynx, trachea and great vessels. Keleman,[1] in commenting on the musculature of the laryngeal vestibule, states that no effective dilator is formed for the laryngeal vestibule which opens only by movements of the epiglottis, these movements being performed only to a slight degree by its own musculature. He comments, too, on the extreme looseness of the suspension of the epiglottis itself which is demonstrated both histologically and by clinical experience: in the latter case this is shown by the improvement of stridor and dyspnœa produced by changes in body position.

Allen *et al.*[2] have recently described two cases of what they considered to be neurogenic stridor.